PRINTED: 05/31/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155524	B. WING		05/14/2013
		_	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R	618 W	GLENBURN ROAD	
GLENBU	RN HOME		LINTO	N, IN 47441	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K010000					
	1	ode Recertification and	K010000	Submission of this Plan of	
	State Licensure	Survey was conducted by		Correction does not constitue	
	the Indiana State	e Department of Health in		admission or agreement by the provider of the truth of facts	9
	accordance with	42 CFR 483.70(a).		alleged or corrections set forth	ion
				the statement of deficiencies.	
	Survey Date: 05	5/14/13		Plan of correction is prepared	
				submitted because of the	
	Facility Number	- 000220		requirements under State and	
	*			Federal Law.	
	Provider Number				
	AIM Number:	100275000			
	Surveyor: Lex l	Brashear, Life Safety			
	Code Specialist				
	At this Life Safe	ety Code survey, Glenburn			
		d not in compliance with			
		or Participation in			
		eaid, 42 CFR Subpart			
	` / '	Safety from Fire and the			
		the National Fire			
		ciation (NFPA) 101, Life			
	Safety Code (LS	SC), Chapter 19, Existing			
	Health Care Occ	cupancies and 410 IAC			
	16.2.				
	This one story fa	acility was determined to			
		00) construction and was			
		d. The facility has a fire			
		ith hard wired smoke			
	<u> </u>				
		corridors, in spaces open			
		and resident sleeping			
	rooms in the 400	0 north hall, 500 north			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000230

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 01	(X3) DATE ( COMPL	
MINDILMIN	or condection	155524		LDING	<del></del>	05/14/	
		100021	B. WIN			00/11/	2010
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD		
GLENBU	RN HOME				I, IN 47441		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	hall, 600 hall, 70		+	TAG	Dia relation,		DATE
		ite rooms, plus battery					
		detectors in the 300 south					
	•	all, 500 south hall and all					
		it resident sleeping					
	•	the 100 and 200 halls.					
		a capacity of 137 and had					
		at the time of this survey.					
	a census of 117 a	at the time of this survey.					
	All areas where	residents have customary					
		nklered. All areas					
	providing facility						
		ept an attached structure					
	_	nance shop and storage					
		from the facility by a two					
	-	nd one detached garage					
	used for facility						
	used for facility	storage.					
	Quality Review	by Robert Booher, Life					
		cialist-Medical Surveyor					
	on 05/17/13.	,					
	The facility was	found not in compliance					
	with the aforeme	entioned regulatory					
	requirements as	evidenced by the					
	following:						

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Event ID: EWDG21

Facility ID: 000230

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 01	(X3) DATE S	ETED
		155524	B. WIN	G		05/14/	2013
	ROVIDER OR SUPPLIER			618 W	ADDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD I, IN 47441		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K010029 SS=E	NFPA 101 LIFE SAFETY CO One hour fire rate hour fire-rated do automatic fire exti accordance with 8 protects hazardou approved automa system option is a separated from or resisting partitions self-closing and nortective plates inches from the binches from the binches from the binches from the binches from potential firesident room state combustible mate with a self closing. This deficient president in room residents, as well within the 300 H.  Findings include  Based on observation of the self-closing and th	DDE STANDARD ad construction (with 3/4 ors) or an approved inguishing system in 3.4.1 and/or 19.3.5.4 us areas. When the tic fire extinguishing used, the areas are ther spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 ottom of the door are .2.1 ation and interview, the tensure residents in 1 of tertments were protected are hazards created in a toring a large amount of the door. The door are actice could affect one 304 and seven other as staff and visitors all.	K01	10029	What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice; This habeen an ongoing problem in which the resident, in the past had refused to remove the storage from her room. The loc Ombudsman has supported the resident in saying it was her right to keep her belongings. Howe the resident has now agreed to remove the storage from her room and have the belongings taken to a family members residence. How other resider having the potential to be affect by the same deficient practice be identified and what correct action(s) will be taken; All residents have the potential to affected by the deficient practice. An audit of every room has be completed and there were no other problems currently identified. What measures with the potential to put into place or what systems.	nts y s cal ee ght ver, o steed will tive be ce. en	06/13/2013

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	OF CORRECTION IDENTIFICATION NUMBER:  155524	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	COMPLETED 05/14/2013
	PROVIDER OR SUPPLIER  JRN HOME	STREET.	ADDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD N, IN 47441	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112
	two walls within the room. The door to this room was not provided with a self closing device. This was acknowledged by the Maintenance Supervisor at the time of observation.  3.1-19(b)		changes will be made to ensuthat the deficient practice does not recur; Walking rounds, exhibit A, will be completed montly to make surooms are not being used as storage for reisdents. A letter exhibit B, will be added to the admission packet explaining rooms cannot be used for excessive storage of personal belongings. How the correct action(s) will be monitored to ensure the deficient practice on the recur, i.e. what quality assuarance program will be printo place; A monthly audit we conducted to make sure room are not being used for excessive storage of personal belongings. This will be report at the Quarterly QA meetings what date the systemic change will be completed; June 13, 2	es  ire  that  il  ive  will  but rill be  ns  il  tted  by ges

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLE	ETED
		155524	B. WIN			05/14/2013	
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			618 W	GLENBURN ROAD		
	RN HOME			LINTON	N, IN 47441		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	+	DATE
K010048 SS=F	LIFE SAFETY CO	ODE STANDARD					
33-F		plan for the protection of					
		or their evacuation in the					
	event of an emer						
	Based on record	review and interview, the	K01	0048	What corrective action(s) will b		06/13/2013
	facility failed to	provide a complete			accomplished for those reside		
	written fire safet	y plan for the protection			found to have been affected by the deficient Practice; The Fil		
	of 117 of 117 res	sidents to accurately			Plan, exhibit C, has been	E	
		afety systems such as the			updated to include when and h	now	
		e smoke compartment,			a smoke compartment should		
	and the use of th	•			evacuated. A section was also		
	extinguisher in the				added to indicate what class fi	re	
	_	ems required by NFPA			extinguishers were located throughout the building. A char	nge	
	_	n, Section 19.7.2.2. LSC			was also made to indicate whe	_	
	-	a written health care			the battery smoke detectors		
	•	afety plan shall provide			sound "in the residents rooms'		
		• • •			Mandatory staff inservicing wil		
	for the following				completed by 6.13.13. How of Residents having the potential		
	(1) Use of alarms				be affected by the same deficient		
	` ′	of alarm to the fire			practice will be identified and		
	department				what corrective action(s) will b	e	
	(3) Response to a				taken; All Residents have the		
	(4) Isolation of f				potential to be affected by the deficient practice. The Fire Pla	<sub>in</sub>	
	` '	f immediate area			has been updated to include	""	
		f smoke compartment			when and how a smoke		
		of floors and building for			compartment should be		
	evacuation				evacuated. A section was also		
	(8) Extinguishme	ent of fire			added to indicate what class fi extinguishers were located	re	
	This deficient pr	actice could affect all			throughout the building. A char	nge	
	occupants in the	event of an emergency.			was also made to indicate whe		
					the battery smoke detectors		
	Findings include	:			sound "in the residents room".		
	_				Mandatory staff inservicing will completed by 6.13.13. What	ı be	
	Based on a revie	w of the facility's			measures will be put into place	e or	
		aredness Fire Plan on			what systemic changes will be		
I			1		1		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155524	A. BUILDING B. WING		05/14/2013	
-				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		/ GLENBURN ROAD		
GLENBLI	RN HOME			N, IN 47441		
				14, 114 77 77 1		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG			
		00 p.m. with the		made to ensure that the defici	ent	
	Maintenance Su	ipervisor present, the Fire		practice does not recur; The above mentioned educational		
	Plan did not ado	dress evacuation of the		points will be added to the		
	smoke comparti	ment and the use of the		annual mandatory staff		
	K-class fire exti	inguisher located in the		inservicing. Staff will be		
		onship with the use of the		monitored during Quarterly fire		
		d extinguishing system.		drills. Fire extinguisher education	tion	
		iew at the time of record		will be added to the annual calendar. How the corrective		
		ntenance Supervisor		action(s) will be monitored to		
	•	he Fire Plan did not		ensure the deficient practice v	vill	
	_			not recur, i.e. what quality		
		ion of the smoke		assurance program will be pu		
	-	nd the use of the K-class		into place; Quarterly fire drills		
	fire extinguishe	r located in the kitchen.			\ <u>\</u>	
	fire extinguishe 3.1-19(b)	r located in the kitchen.		and annual inservicing will be monitored at each Quarterly Comeeting to determine if the Planof Correction is being followed. Inservicing signature sheets will be monitored to determine staff compliance. To will be monitored Quarterly, Exhibit D, for one year and the will be monitored Annually thereafter. By what date the systemic changes will be completed; June 13, 2013.	an e his	

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NAME OF PROVIDER OR SUPPLIER  GLENBURN HOME  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SS=F  NFPA 101  LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may  STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441  STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441  CAGH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX TAG  PREFIX PREFIX CACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX TAG  PREFIX TAG  PREFIX PREFIX CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  (AS)  COMPLETION DATE	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  GLENBURN HOME  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K010051 SS=F  K010051 SS=F  K010051 SS=F  K010051 SS=F  K010051 A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01		
GLENBURN HOME  (X4) ID PREFIX TAG  KO10051  NFPA 101  LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may		155524	B. WIN	G		05/14/2	2013
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   NFPA 101	NAME OF PROVIDER OR SUPPLIE		•				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K010051  SS=F  LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may	GLENBURN HOME						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  K010051 SS=F  NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may	(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
K010051 SS=F  NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may	`				CROSS-REFERENCED TO THE APPROPRIA	TE	
SS=F  LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may							
Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may							
warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may		-					
Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may		•					
is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may	_						
detection or extinguishing system operation. Pull stations in patient sleeping areas may							
Pull stations in patient sleeping areas may							
	Pull stations in pa	atient sleeping areas may					
be omitted provided that manual pull	· · · · · · · · · · · · · · · · · · ·	·					
stations are within 200 feet of nurse's							
stations. Pull stations are located in the path of egress. Electronic or written records of							
tests are available. A reliable second source	_						
of power is provided. Fire alarm systems							
are maintained in accordance with NFPA 72							
and records of maintenance are kept readily							
available. There is remote annunciation of							
the fire alarm system to an approved central station. 19.3.4, 9.6	station. 19.3.4	, 9.6					
			K01	0051			05/23/2013
facility failed to install 1 of 1 fire alarm  accomplished for those residents	facility failed to	install 1 of 1 fire alarm					
systems in accordance with NFPA 72.  found to have been affected by the deficient practice; On May	systems in accor	dance with NFPA 72.					
NFPA 72, 1-5.4.6 requires trouble signals  23rd, 2013, the Digital Alarm	NFPA 72, 1-5.4	6 requires trouble signals					
to be located in an area where it is likely  Communicator Transmittal was	to be located in	an area where it is likely			Communicator Transmittal wa	s	
to be heard. NFPA 72, 1-5.4.4 requires relocated from a unpopulated	to be heard. NF	PA 72, 1-5.4.4 requires					
fire alarms, supervisory signals, and mechanical room to a 24 hour populated nurses station. This	fire alarms, supe	ervisory signals, and					
trouble signals to be distinctive and populated nurses station. This was completed by the company	trouble signals t	o be distinctive and			1		
descriptively annunciated. This deficient Vanguard. How other residents							
practice could affect all residents, staff having the potential to be affected	1 .				having the potential to be affect	cted	
and visitors in the facility by the same deficient practice will	•	· ·					
be identified and what corrective						ve	
action(s) will be taken; All   Findings include:   resients have the potential to be	Findings include	2:				ne	
affected by the deficient practice.	1 manigo morado	·•					
Based on observations on 05/14/13  The Digital Alarm Communicator	Rased on observ	rations on 05/14/13					
Transmittal was relocated from							
between 1:00 p.m. and 3:00 p.m. during a an unpopulated mechanical room	Detweell 1.00 p.	ni. and 5.00 p.m. dufing a			an unpopulated mechanical ro	om	

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	01	(X3) DATE SURVEY  COMPLETED
	155524	A. BUILDING		05/14/2013
		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF F	PROVIDER OR SUPPLIER		GLENBURN ROAD	
GLENBU	RN HOME	LINTON	N, IN 47441	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	tour of the facility with Maintenance Supervisor, the Digital Alarm Communicator Transmitter (DACT) was located in the Main Mechanical Room. When the DACT was placed in trouble from phone line failure at 2:30 p.m., the DACT did actuate a local audio trouble signal, however, the local trouble signal at the DACT did not activate a trouble signal at any of the three nurses' stations. The Main Mechanical Room was located in an area not occupied by staff at all times of the day, and the local audio trouble signal at the DACT could not be heard at any of the three nurses' stations. Based on interview at 2:35 p.m., the Maintenance Supervisor acknowledged the phone line failure did not send a trouble signal to any of the three nurses' stations.  3.1-19(b)	TAG	to a 24 hour populated nurses station on 5.23.13. The was completed by the company Vanguard. What measure will put into place or what systemichanges will be made to ensut that the deficient practice does not recur; The Digital Alarm Communicator Transmittal warelocated and permantly place the wall in the new 24 hour populated area. How the corrective action(s) will be monitored to ensure the defici practice will not recur, i.e. what quality assurance program will put into place; The placement be monitored quarterly for one year, exhibit E, and then will I monitored annually thereafter the Quarterly QA meetings. If what date the systemic change will be completed; May 23, 20	I be c re s s s e on  ent at I be t will e oe in By es

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLI	
		155524	B. WIN	G		05/14/	2013
	ROVIDER OR SUPPLIER			618 W	ADDRESS, CITY, STATE, ZIP CODE GLENBURN ROAD N, IN 47441		
	RN HOME  SUMMARY STATE (EACH DEFICIENCE REGULATORY OR NFPA 101  LIFE SAFETY CO. If there is an auto installed in accord Standard for the I Systems, to proving all portions of the properly maintains NFPA 25, Standa Testing, and Mair Fire Protection Sysupervised. There water supply for the sprinkler systems flow and tamper selectrically connectains accordance with requires sprinkle tested and maintain NFPA 25, Standa Testing and Mair Fire Protection Systems were instanced and maintain NFPA 25, Standa Testing and Mair Fire Protection Systems was prinkle tested and maintain NFPA 25, Standa Testing and Mair Fire Protection Systems was prinkle tested and maintain the systems of Inspections, Testing and main drain. The protection of the systems was provided the systems was prinkle tested and maintain the systems was provided to systems was prinkle tested and maintain the systems was provided to the systems was provided	DDE STANDARD matic sprinkler system, it is dance with NFPA 13, installation of Sprinkler de complete coverage for building. The system is ed in accordance with rd for the Inspection, intenance of Water-Based victems. It is fully e is a reliable, adequate the system. Required are equipped with water switches, which are cted to the building fire 19.3.5 review and interview, the ensure 2 of 2 sprinkler spected quarterly in LSC 9.7 Section 9.7.5 r systems to be inspected, ained in accordance with ard for the Inspection, intenance of Water-Based systems. NFPA 25, Table Sprinkler System ing and Maintenance, y testing of alarm devices NFPA 25, 1.8 requires	K01	618 W	GLENBURN ROAD	oe onts  y  of  rans  or  nor  to  nat  us  sected	(X5) COMPLETION DATE  05/24/2013
	-	ficient practice could ts, as well as staff and			be identified and what correcti action(s) will be taken; All	ve	
	visitors.	is, as well as stall allu			residents have the potential of being affected. This was		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			01	(X3) DATE S COMPL	
11112 12111	or condition,	155524		LDING	<del></del>	05/14/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				GLENBURN ROAD		
	RN HOME		_		N, IN 47441		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Findings include  Based on review system quarterly 05/14/13 at 12:1 Maintenance Sulwas no first quar and March) 2013 system inspection interview at the Maintenance Sul	of the facility's sprinkler inspection records on 5 p.m. with the pervisor present, there ter (January, February, 8 quarterly sprinkler in available. Based on time of record review, the pervisor stated there was em inspection performed			identified shortly after the inspections were due to be done. Glenburn Home had be scheduled and completed time in the past. So, due to the oversight of US Sprinkler, the Maintenance Supervisor will k a calendar that will indicate for him to check one month prior to the end of the quarter. It will be the Maintenance Supervisor's responsibility to make sure US Sprinkler still had us scheduled and is planning doing the survey within the allutime frame. What measure we be put into place or what syste changes will be made to ensure the deficient practice does not occur; The Maintenance Supervisor will keep a calendar that will indicate for he to check one month prior to the end of the quarter. It will be the Maintenance Supervisor's responsibility to make sure US Sprinkler still has us scheduled and is planning on doing the survey within the alloted time frame. How the corrective action(s) will be monitored to ensure the deficient practice wont recur; i.e., what quality assurance program will be put into place; An audit, Exhibit He will be completed every quart to review in the Quarterly QA meeting to make sure that we acheiving compliance. By who date the systemic changes will completed; May 24, 2013	en ely eep as on oted ill emic re e e s d	

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Event ID: EWDG21

Facility ID: 000230

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPL	ETED
		155524	B. WIN			05/14/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	GLENBURN ROAD		
GI ENRU	RN HOME				N, IN 47441		
					,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K010144	NFPA 101						
SS=C	LIFE SAFETY CO						
		spected weekly and oad for 30 minutes per					
		nce with NFPA 99.					
	3.4.4.1.	nee warm in 1700.					
		review and interview, the	K01	0144	What corrective action(s) will b	e	06/03/2013
		provide complete			accomplished for those resider		
		or the testing of 2 of 2			found to have been affected by		
		rators providing power to			the deficient practice; The fac		
					will complete an annual load to	est	
		ghting systems. LSC			on 6.3.13 by Vangaurd. How		
		A 99, Health Care			other residents having the potential to be affected by the		
	Facilities, 3-4.4.	1.1(a) requires monthly			same deficient practice will be		
	testing of the ger	nerator set shall be in			identified and what corrective		
	accordance with	NFPA 110, the Standard			action(s) will be taken; All		
	for Emergency a	nd Standby Power			residents have the potential to	be	
		110, 6-4.2 requires			affected. The facility will compl		
		Level 1 and 2 service			an annual load test on 6.3.13 b	-	
	_	d under operating			Vanguard. What measures wi		
					be put in place or what system changes will be made to ensur		
		t less than 30 percent of			that the deficient practice does		
	` `	ency Power Supply)			not recur; An annual load test		
		at least monthly, for a			be performed. This years test i		
	minimum of 30 i	minutes. NFPA 99,			scheduled on 6.3.13. Therefore	е,	
	3-5.4.2 requires a	a written record of			our annual test will be perform	ed	
	inspection, perfo	ormance, exercising			within the next year. How the		
		rs shall be regularly			corrective action(s) will be	nt	
		available for inspection			monitored to ensure the deficient practice will not recur, i.e. what		
		having jurisdiction. This			quality assurance program will		
	deficient practice				put into place; A calendar, ext		
	_				G, will be used to monitor the		
		l as staff and visitors in			annual inspection. This will be		
	the facility.				reported to the QA process at		
					next meeting for completion ar		
	Findings include	:			then annually thereafter. An autool, exhibit I, will be utilized.		
					what date the systemic change	-	
	Based on review	of the facility's			will be completed; 6.3.13		

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DESCRIPTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	01	(X3) DATE SURVEY  COMPLETED		
	155524	A. BUILDING		05/14/2013		
		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF F	ROVIDER OR SUPPLIER	618 W GLENBURN ROAD				
GLENBU	RN HOME	LINTON	I, IN 47441			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE		
	Generator Log on 05/14/13 at 12:50 p.m. with the Maintenance Supervisor present,					
	the generator log form documented the					
	generators were tested weekly under load,					
	however, there was no documentation on					
	the form showing the generator was					
	exercised under operating conditions or					
	not less than 30 percent of the EPS					
	(Emergency Power Supply) nameplate					
	rating for a minimum of 30 minutes					
	during the past twelve months. During an					
	interview at the time of record review, the					
	Maintenance Supervisor confirmed the					
	weekly generator log did not include					
	documentation the generator was					
	exercised under operating conditions or					
	not less than 30 percent of the EPS					
	(Emergency Power Supply) nameplate					
	rating for a minimum of 30 minutes.					
	3.1-19(b)					
	3.1-17(0)					

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